University Hospitals

ATTACHMENT "B"

University Hospitals
Employee Assistance

Agreement to Submit to an Alcohol and/or Drug Screen

I have been informed that University Hospitals (UH) is concerned that I may be under the influence of alcohol or drugs, or may have violated the UH policy against alcohol and/or drug use. My behavior and/or ability to perform my job duties are in question and as a result, I have been requested to submit to an Alcohol and/or Drug Screen(s) by blood and/or urine test(s) administered by the Corporate Health Service or designated area.

I understand that the results of the toxicology screen will be released to the Employee Assistance Program. In specific cases (i.e. diversion of drugs) results of the screening will also be released to the entity HR representative. Based on these results and other documentation, department management will determine a course of action.

I agree to the requested Alcohol and/or Drug Screen(s) through blood and/or urine tests by the Corporate Health Service or designated area and in recognition of this agreement, sign this consent form.

[signature] 2.15.17
Employee Signature Date

Carol Heilman 2-15-17
Witness Date

Employee Refusal

I refuse to comply with the requested Alcohol and/or Drug Screen(s). I understand that I have 20 minutes to consent after initial refusal of this request. After this time has elapsed and I continue to refuse this request I may be subject to corrective action up to and including discharge (or immediate discharge).

Employee Signature Date Time

Witness Date Time

NON-REGULATED 5 PART DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO.

MEDTOX LABORATORIES, INC.
402 W County Rd D
St. Paul, MN 55112
(651) 636-7466
(800) 832-3244

STEP 1 To be completed by **COLLECTOR** or **EMPLOYER REPRESENTATIVE** Account #

A. Employer Name, Address, I.D. No.

B. MRO Name, Address, Phone and Fax No.

LAB ACCESSION NO.

EMPLOYER NAME EAP

Account #

Donor I.D. [redacted]

C. Donor Name (Last, First) MOSS DEBORAH

Donor Daytime Phone 3302259597

D. Reason for Test ☐ Pre-employment ☒ Random ☐ Reasonable Suspicion/Cause ☐ Return To Duty ☐ Follow-up ☐ Post Accident ☐ Other (Specify)

E. Collection Site Name

Collector Phone No.

Collector Fax No.

F. Test(s) Ordered X

STEP 2: COMPLETED BY COLLECTOR

Read specimen temperature within 4 minutes. Is temperature between 90° and 100° F? ☒ Yes ☐ No, Enter Remark

Specimen Collection: ☒ Split ☐ Single ☐ None Provided (Enter Remark) ☐ Observed (Enter Remark)

14008

REMARKS

STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 5 on Copy 2 (MRO Copy)

STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY LABORATORY

I certify that the specimen given to me by the donor identified in the certification section on Copy 2 of this form was collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable requirements.

X Signature of Collector

(PRINT) Collector's Name (First, MI, Last)

Time of Collection 1500 ☐ AM ☒ PM

Date (Mo./Day/Yr.) 02/15/2017

SPECIMEN BOTTLE(S) RELEASED TO:
Name of Delivery Service Transferring Specimen to Lab
☒ FedEx ☐ Local Courier ☐ Other

STEP 5: COMPLETED BY DONOR

I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information provided on this form and on the label affixed to each specimen bottle is correct.

X Signature of Donor

(PRINT) Donor's Name (First, MI, Last) DEBORAH MOSS

Date (Mo. / Day /Yr.)

Daytime Phone No. ( ) 330-225-9597

Evening Phone No. ( )

Date of Birth 5/31/65 Mo. Day Yr.

330.225.9597

STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN

In accordance with applicable requirements, my determination/verification is:

☐ NEGATIVE ☐ POSITIVE ☐ TEST CANCELLED ☐ DILUTE
☐ REFUSAL TO TEST BECAUSE: ☐ ADULTERATED ☐ SUBSTITUTED

REMARKS

X Signature of Medical Review Officer

(PRINT) Medical Review Officer's Name (First, MI, Last)

Date (Mo./Day/Yr.)

STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT SPECIMEN

In accordance with applicable requirements, my determination/verification

☐ RECONFIRMED ☐ FAILED TO RECONFIRM - REASON

X Signature of Medical Review Officer

(PRINT) Medical Review Officer's Name (First, MI, Last)

Date (Mo./Day/Yr.)

NON-REGULATED 5 PART DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO.

MEDTOX LABORATORIES, INC.
402 W County Rd D
St. Paul, MN 55112
(651) 636-7466
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STEP 1 To be completed by **COLLECTOR** or **EMPLOYER REPRESENTATIVE** Account #

A. Employer Name, Address, I.D. No. EAP

B. MRO Name, Address, Phone and Fax No.

LAB ACCESSION NO.

Account #

Donor I.D. [redacted]

C. Donor Name (Last, First) MOSS DEBORAH

Donor Daytime Phone 3302259597

D. Reason for Test ☐ Pre-employment ☒ Random ☐ Reasonable Suspicion/Cause ☐ Return To Duty ☐ Follow-up ☐ Post Accident ☐ Other (Specify)

E. Collection Site Name

Collector Phone No.

Collector Fax No.

F. Test(s) Ordered X

STEP 2: COMPLETED BY COLLECTOR

Read specimen temperature within 4 minutes. Is temperature between 90° and 100° F? ☒ Yes ☐ No, Enter Remark

Specimen Collection: ☒ Split ☐ Single ☐ None Provided (Enter Remark)

14008

☐ Observed (Enter Remark)

REMARKS

STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 5 on Copy 2 (MRO Copy)

STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY LABORATORY

I certify that the specimen given to me by the donor identified in the certification section on Copy 2 of this form was collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable requirements.

X _____ Signature of Collector

_____ (PRINT) Collector's Name (First, MI, Last)

Time of Collection 1500 ☐ AM ☒ PM

Date (Mo./Day/Yr.) 02/15/17

SPECIMEN BOTTLE(S) RELEASED TO:

Name of Delivery Service Transferring Specimen to Lab

☒ FedEx ☐ Local Courier ☐ Other _____

STEP 5: COMPLETED BY DONOR

I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information provided on this form and on the label affixed to each specimen bottle is correct.

X _____ Signature of Donor

_____ (PRINT) Donor's Name (First, MI, Last) Deborah Moss

Date (Mo. / Day /Yr.) 2/15/17

Daytime Phone No. ( ) 330.225.9597

Evening Phone No. ( ) 330.225.9597

Date of Birth 5/31/59 Mo. Day Yr.

STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN

In accordance with applicable requirements, my determination/verification is:

☐ NEGATIVE ☐ POSITIVE ☐ TEST CANCELLED ☐ DILUTE

☐ REFUSAL TO TEST BECAUSE: ☐ ADULTERATED ☐ SUBSTITUTED

REMARKS _____

X _____ Signature of Medical Review Officer

_____ (PRINT) Medical Review Officer's Name (First, MI, Last)

Date (Mo./Day/Yr.)

STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT SPECIMEN

In accordance with applicable requirements, my determination/verification

☐ RECONFIRMED ☐ FAILED TO RECONFIRM - REASON

X _____ Signature of Medical Review Officer

_____ (PRINT) Medical Review Officer's Name (First, MI, Last)

Date (Mo./Day/Yr.)

COPY 4 - EMPLOYER COPY - SEND TO EMPLOYER

A-14A (9/12) Mfg. 10/12

Moss Affidavit EXHIBIT 8

Alcohol Testing Form

(The instructions for completing this form are on the back of Copy 3)

Step 1: TO BE COMPLETED BY ALCOHOL TECHNICIAN

A: Employee Name Deborah Moss (Print) (First, M.I., Last)

B: SSN or Employee ID No. [redacted]

C: Employer Name / Street / City, State, Zip: University Hospitals Cleveland Medical Center, Employee Health, MCCO 4th Floor, 11100 Euclid Avenue, Cleveland, OH 44106-6029

DER Name and Telephone No.: Paul Miotto, MD (___) DER Name / DER Phone Number

D: Reason for Test: X Random ☐ Reasonable Susp ☐ Post-Accident ☐ Return to Duty ☐ Follow-up ☐ Pre-employ

STEP 2: TO BE COMPLETED BY EMPLOYEE

I certify that I am about to submit to alcohol testing and that the identi... correct.

Signature of Employee

STEP 3: TO BE COM...

(If the technician condu... each technician must con... individual, that I am qual...

TECHNICIAN: X BAT ☐ ... ☐ Yes ☐ No

SCREENING TEST: *(For BA... testing device is not designed to print.*

Test #	Testing Device Name	De... # OR Lot # & Exp Date	Activation Time	Reading Time	Result

CONFIRMATION TEST: *Results MUST be affixed to each copy of this form or printed directly onto the form.*

REMARKS:

University Hospitals Cleveland Medical Center
Employee Health, MCCO 4th Floor
11100 Euclid Avenue
Cleveland, OH 44106-6029

Alcohol Technician's Company: Carol Heilman RN

Company Street Address

(PRINT) Alcohol Technician's Name (First, M.I., Last)

Company City, State, Zip ___ Phone Number (___)

Signature of Alcohol Technician: Carol Heilman RN

Date Month Day Year: 02/15/2017

STEP 4: TO BE COMPLETED BY EMPLOYEE IF TEST RESULT IS POSITIVE.

I certify that I have submitted to the alcohol test, the results of which are accurately recorded on this form. I understand that I must not drive, perform safety-sensitive duties, or operate heavy equipment because the results are positive.

Signature of Employee ___ Date Month Day Year

FOSTER SPECIAL INSTRUMENTS 513-891-0868 • P/N INDOT

CMI, Inc.
Intoxilyzer 400
Ser No: 95858D

Test No: 0770
Date: 02/15/17
Test Type: SCREENING

Diagnostics: PASS
Time of Test: 14:36
Result: .000 %BAC

Donor Name: Deborah Moss

Signature: Deborah Moss

Operator Name: Carol Heilman

Signature: Carol Heilman

Affix ... Print Additional Results ... etc. Here

Affix With Tamper Evident Tape

Alcohol Testing Form

(The instructions for completing this form are on the back of Copy 3)

Step 1: TO BE COMPLETED BY ALCOHOL TECHNICIAN

A: Employee Name Deborah Moss
(Print) (First, M.I., Last)

B: SSN or Employee ID No. [redacted]

C: Employer Name
Street
City, State, Zip
University Hospitals Cleveland Medical Center
Employee Health, MCCO 4th Floor
11100 Euclid Avenue
Cleveland, OH 44106-6029

DER Name and Telephone No.
Paul Miotto, MD ( )
DER Name DER Phone Number

D: Reason for Test: ☐ Random ☐ Reasonable Susp ☐ Post-Accident ☐ Return to Duty ☐ Follow-up ☐ Pre-employment

STEP 2: TO BE COMPLETED BY EMPLOYEE

I certify that I am about to submit to alcohol testing and that the identifying information provided on the form is true and correct.

Signature of Employee
Date Month Day Year 2/15/17

STEP 3: TO BE COMPLETED BY ALCOHOL TECHNICIAN

(If the technician conducting the screening test is not the same technician who will be conducting the confirmation test, each technician must complete their own form.) I certify that I have conducted alcohol testing on the above named individual, that I am qualified to operate the testing device(s) identified, and that the results are as recorded.

TECHNICIAN: ☐ BAT ☐ STT DEVICE: ☐ SALIVA ☐ BREATH* 15-Minute Wait: ☐ Yes ☐ No

SCREENING TEST: *(For BREATH DEVICE* write in the space below only if the testing device is not designed to print.)*

Test #	Testing Device Name	Device Serial # OR Lot # & Exp Date	Activation Time	Reading Time	Result

CONFIRMATION TEST: *Results MUST be affixed to each copy of this form or printed directly onto the form.*

REMARKS:
University Hospitals Cleveland Medical Center
Employee Health, MCCO 4th Floor
11100 Euclid Avenue
Cleveland, OH 44106-6029

Alcohol Technician's Company
Company Street Address
(PRINT) Alcohol Technician's Name (First, M.I., Last) Carol Heilman RN
Company City, State, Zip ( ) Phone Number
Signature of Alcohol Technician Carol Heilman RN
Date Month Day Year 02/15/2017

STEP 4: TO BE COMPLETED BY EMPLOYEE IF TEST RESULT IS POSITIVE.

I certify that I have submitted to the alcohol test, the results of which are accurately recorded on this form. I understand that I must not drive, perform safety-sensitive duties, or operate heavy equipment because the results are positive.

Signature of Employee
Date Month Day Year

Affix or Print Screening Results Here

Affix With Tamper Evident Tape

Affix or Print Confirmation Results Here

Affix With Tamper Evident Tape

Affix or Print Additional Results e.g. Calibration check, etc. Here

Affix With Tamper Evident Tape

FOSTER SPECIAL INSTRUMENTS 513-891-0868 • P/N INDOT

COPY 3 - ALCOHOL TECHNICIAN RETAINS

NON-REGULATED 5 PART DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO.

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402 W County Rd D
St. Paul, MN 55112
(651) 636-7466
(800) 832-3244

STEP 1 To be completed by **COLLECTOR** or **EMPLOYER REPRESENTATIVE** Account #

A. Employer Name, Address, I.D. No.

EMPLOYER NAME EAP

B. MRO Name, Address, Phone and Fax No.

DR PAUL MIOTTO
39000 CENTER RIDGE ROAD
NORTH RIDGEVILLE, OH 44039

LAB ACCESSION NO.

Account # 4 0 1 6 9 2 4

Donor I.D. [redacted]

C. Donor Name (Last, First) MOSS DEBORAH

Donor Daytime Phone 3302259597

D. Reason for Test ☐ Pre-employment ☑ Random ☐ Reasonable Suspicion/Cause ☐ Return To Duty ☐ Follow-up ☐ Post Accident ☐ Other (Specify)

E. Collection Site Name

CLEVELAND CLINIC EMPLOYEE HEALTH
9500 EUCLID AVE MCCO 4TH FLOOR
CLEVELAND, OH 44106

Collector Phone No.

Collector Fax No.

F. Test(s) Ordered ☑ 35513 ☐ 97111

STEP 2: COMPLETED BY COLLECTOR
Read specimen temperature within 4 minutes. Is temperature between 90° and 100° F? ☑ Yes ☐ No, Enter Remark

Specimen Collection: ☑ Split ☐ Single ☐ None Provided (Enter Remark) ☐ Observed (Enter Remark)

14008

REMARKS

STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 5 on Copy 2 (MRO Copy)

STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY LABORATORY

I certify that the specimen given to me by the donor identified in the certification section on Copy 2 of this form was collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable requirements.

X Carol Heilman
Signature of Collector

Carol Heilman
(PRINT) Collector's Name (First, MI, Last)

Time of Collection 1500 ☐ AM ☑ PM

Date (Mo./Day/Yr.) 02/15/2017

SPECIMEN BOTTLE(S) RELEASED TO:
Name of Delivery Service Transferring Specimen to Lab
☐ FedEx ☐ Local Courier ☐ Other

STEP 5: COMPLETED BY DONOR

I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information provided on this form and on the label affixed to each specimen bottle is correct.

X DM
Signature of Donor

I Deborah Moss
(PRINT) Donor's Name (First, MI, Last)

2/15/17
Date (Mo. / Day /Yr.)

Daytime Phone No. ( ) 330.225979-7 erigm

Evening Phone No. ( )

Date of Birth 5/31/62
Mo. Day Yr.

330.225.9597

STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN

In accordance with applicable requirements, my determination/verification is:

☐ NEGATIVE ☐ POSITIVE ☐ TEST CANCELLED ☐ DILUTE
☐ REFUSAL TO TEST BECAUSE: ☐ ADULTERATED ☐ SUBSTITUTED

REMARKS

X
Signature of Medical Review Officer

(PRINT) Medical Review Officer's Name (First, MI, Last)

Date (Mo./Day/Yr.)

STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT SPECIMEN

In accordance with applicable requirements, my determination/verification

☐ RECONFIRMED ☐ FAILED TO RECONFIRM - REASON

X
Signature of Medical Review Officer

(PRINT) Medical Review Officer's Name (First, MI, Last)

Date (Mo./Day/Yr.)